THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM LAURENS COUNTY
Court of Common Pleas

Eugene C. Griffith, Jr., Circuit Court Judge

Appellate Case No. 2017-001064

Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,..... Appellants

v.

Laurens County Health Care System and Greenville Health System..... Respondents

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INITIAL BRIEF OF RESPONDENTS

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STATEMENT OF ISSUES ON APPEAL

1. Did the circuit court err in holding that Respondents/Defendants owed no legal duty to ensure there was medical malpractice liability insurance available to cover the default judgments Appellants/Plaintiffs received in separate medical malpractice actions they previously brought against their physician who was not a servant/employee of Respondents/Defendants?
2. Though not ruled on by the circuit court, was summary judgment also appropriate on the basis that Defendants' alleged acts or omissions did not proximately cause Plaintiffs' injuries and/or Plaintiffs' claims were barred by the statute of limitations?

STATEMENT OF THE CASE

Appellants/Plaintiffs Chris Katina McCord and Janice Sherfield each underwent surgical procedures performed by Dr. Byron Brown at Laurens County Hospital between December 2008 and May 2009. In subsequent civil actions (*McCord v. Brown*, C.A. 11-CP-30-1141 and *Sherfield v. Brown*, C.A. No. 12-CP-30-753), both women alleged they suffered injuries as a result of Dr. Brown's alleged negligence during their surgeries. Neither Laurens County Health Care System ("Laurens") nor Greenville Health System ("GHS") (collectively referred to hereinafter as "Defendants") were parties to either of those actions. Ultimately, on March 11, 2014, the McCords and Sherfields were both able to obtain default judgments against Dr. Brown and his practice, but Plaintiffs have been unable to collect those judgments.

On March 26, 2014, Plaintiffs filed the instant action against Laurens and GHS[1], essentially alleging that it was Laurens's fault that Plaintiffs have been unable to collect the judgments they received against Dr. Brown. More specifically, Plaintiffs alleged that Laurens breached a contractual

1 There were no allegations that GHS was independently liable to Plaintiffs. GHS was named as a defendant solely upon the basis that Plaintiffs alleged that subsequent to the acts giving rise to the causes of action, Laurens entered into an agreement of consolidation or merger with GHS whereby GHS assumed the existing liabilities of Laurens. Sec. Am. Compl. ¶ 4.

duty and/or an independent duty arising from the "special relationship" between the parties to ensure that Dr. Brown had medical malpractice insurance coverage for their claims against him. Defendants denied that any such legal duty was owed to Plaintiffs and, after extensive discovery, moved for summary judgment on that basis. The court heard Defendants' motion on January 6, 2017 and granted summary judgment by way of an order dated February 28, 2017 ("Order"). Plaintiffs filed a motion to alter or amend the judgment, which was denied by the court by way of an order dated April 4, 2017. Plaintiffs filed notice of the instant appeal on April 27, 2017.

STATEMENT OF FACTS[2]

This case arises out of surgeries that were performed on Appellants/Plaintiffs Chris Katina McCord and Janice Sherfield at Laurens County Hospital ("Hospital"), part of Laurens County Health System, from December 2008 to May 2009 by Dr. Byron Brown. It is undisputed that at the time of the surgeries, Dr. Brown had surgical privileges at the Hospital, but he was not employed by Laurens.[3] Dr. Brown had his own practice with an office located offsite from the Hospital. It is undisputed that pursuant to the Hospital Medical Staff Bylaws ("Bylaws"), Dr. Brown had to maintain medical malpractice insurance in order to retain privileges at the Hospital. And, it is undisputed that at the time of the surgeries, he was in compliance with the Bylaws, as Dr. Brown had a claims-made medical malpractice liability insurance policy through Joint Underwriting Association

2 The following facts were set forth in Defendants' Motion for Summary Judgment and have never been contested by Plaintiffs. See Defs.' Mot. Summ. J., pp. 2-4; see generally Pls.' Mem. Opp'n. Summ. J. Likewise, the circuit court found the facts were undisputed (see Order, p. 2-4) and Plaintiffs have not challenged that finding in their Initial Brief. See Brown v. Gurney, 201 U.S. 184, 189 (1906)(a fact assumed as true in the trial court cannot be contested in the appellate court)

3 There was a February 14, 2002 Agreement between Dr. Brown and Laurens whereby Laurens agreed to subsidize Dr. Brown's practice for three years (hereinafter "Subsidy Contract"), because the Hospital felt there were an insufficient number of OB/GYN physicians in the area. However, the Subsidy Contract made clear that Dr. Brown was an independent contractor who was free to admit patients at any hospital and maintain privileges to perform surgeries at any hospital.

("JUA") with coverage limits of $200,000 per claim and $600,000 annual aggregate. In addition, Dr. Brown had excess coverage through Patients' Compensation Fund, which pushed his total coverage up to $1,000,000 per claim and $3,000,000 annual aggregate.

A few months after the surgeries on Mrs. McCord and Mrs. Sherfield, in July, 2009, Dr. Brown decided to switch his medical malpractice insurance carrier from JUA to MAG Mutual. He bought a claims-made policy from MAG Mutual, which covered claims arising on or after July 9, 2009. When he made the change he declined to purchase either "tail" or "prior bad acts" coverage, which meant there would be no coverage for previously unreported claims that occurred prior to July 9, 2009. As a result, since neither Mrs. McCord nor Mrs. Sherfield put Dr. Brown, or anyone else, on notice that they planned to file a claim against him until well after July 9, 2009, there was no insurance coverage for either of their claims.

Following their surgeries, both Mrs. McCord and Mrs. Sherfield continued to experience issues and both had to seek additional medical care in an attempt to resolve those issues. As a result, they both decided to pursue legal actions against Dr. Brown. They both retained Joseph G. Wright, III of McGowan, Hood & Felder, LLC as their counsel. Mrs. McCord had retained Mr. Wright by July, 2010, while Mrs. Sherfield retained him in May 2011. A Notice of Intent ("NOI") was filed on behalf of Mrs. McCord on July 29, 2011. The NOI mediation took place on December 1, 2011. Plaintiffs have admitted that as of that mediation, Mr. Wright was aware of the possibility that Dr. Brown did not have medical malpractice insurance coverage for the claims being brought by both the McCords and Sherfields.

Despite knowledge of the fact that Dr. Brown lacked insurance coverage for their claims, the McCords and Sherfields continued their legal actions against him. The McCords filed their Complaint against Dr. Brown and his practice on December 9, 2011. They did not name Laurens as

a defendant in that action or assert any allegations against Laurens. The Sherfields filed their Complaint against Dr. Brown and his practice on September 25, 2012. Like the McCords, they did not name Laurens or assert any allegations against Laurens.

While those actions were pending, Dr. Brown moved out of the country and refused to continue participating in the defense of the actions. As a result, both the McCords and Sherfields were ultimately able to obtain default judgments against Dr. Brown and his practice. (See C.A. No. 11-CP-30-1141, March 11, 2014 Judgment in the amount of $1,480,457 for Chris Katina McCord and $50,000 for Christopher McCord and C.A. No. 12-CP-30-753, March 11, 2014 Judgment in the amount of $1,468,580 for Janice Sherfield and $50,000 for Jerry Sherfield.) To date, however, Plaintiffs have been unable to collect on those judgments.

ARGUMENT

I. Standard of Review

Summary judgment is appropriate when it is clear that there is no genuine issue of material fact and the conclusions and inferences to be drawn from the facts are undisputed. Calvert v. House Beautiful Paint and Decorating Ctr., Inc., 313 S.C. 494, 443 S.E.2d 398 (1994). "The purpose of summary judgment is to expedite the disposition of cases which do not require the services of a fact finder." Dawkins v. Fields, 354 S.C. 58, 69, 580 S.E.2d 433, 438 (2003) (quoting George v. Fabri, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001)). When a plaintiff cannot establish facts to meet all the elements of the cause of action, summary judgment is appropriate. Bessinger v. Bi-Lo, Inc., 329 S.C. 617, 496 S.E.2d 33 (Ct. App. 1997); Hunter v. Dixie Home Stores, 101 S.E.2d 262, 232 S.C. 139 (1957). A party may not rely upon an issue of fact that is not genuine or an inference which is not reasonable to rebut a motion for summary judgment. Main v. Corley, 281 S.C. 525, 316 S.E.2d 406 (1984).

Plaintiffs contend that Laurens breached a legal duty owed to them. "A legal duty is that which the law requires to be done or forborne with respect to a particular individual or the public at large." Byerly v. Connor, 301 S.C. 441, 443 415 S.E.2d 796, 798 (1992). A legal duty may be created by statute, a contractual relationship, status, property interest, or some other special circumstance. Madison v. Babcock Ctr., Inc., 371 S.C. 123, 136, 638 S.E.2d 650, 656 (2007). The court must determine, as a matter of law, whether the law recognizes a particular duty. Id. If there is no duty, then the defendant is entitled to summary judgment as a matter of law. Id.

II. The Circuit Court Correctly Ruled that Laurens Did Not Owe a Duty to Plaintiffs, Either in Contract or Tort, to Ensure that Dr. Brown Had Medical Malpractice Insurance Coverage for Their Claims Against Him.

In the instant action, the circuit court correctly ruled as a matter of law that Defendants owed Plaintiffs no legal duty to ensure that Dr. Brown had medical malpractice insurance to cover the default judgments they received against him.

A. Defendants Did Not Owe Plaintiffs a Contractual Duty to Ensure that Dr. Brown Had Medical Malpractice Insurance

In all phases of a claim based on breach of contract, it is the court's duty to interpret and enforce the contract the parties actually made for themselves and the court cannot, under the guise of interpretation, create a better or different contract than the one the parties actually made. See Sphere Drake Ins. Co. v. Litchfield, 313 S.C. 471, 438 S.E.2d 275, 277 (Ct. App. 1993) (court "is limited to interpretation of the contract made by the parties" and "is without authority to alter a contract by construction or to make a new contract for the parties"); Chan v. Thompson, 302 S.C. 285, 395 S.E.2d 731, 734 (Ct. App. 1990) ("The rights of the parties must be measured by the contract which the parties themselves made, regardless of its wisdom, reasonableness, or failure of the parties to guard their rights carefully") (citations omitted). If the contract is unambiguous, it must be construed

according to the terms the parties have used, and the terms are to be interpreted in their plain, ordinary, and popular sense. Litchfield, supra. The court's duty is to enforce the contract made by the parties regardless of the hardship that may create for one of the parties. Gamble, Givens & Moody by Gamble v. Moise, 288 S.C. 210, 218, 342 S.E.2d 147, 151 (Ct. App. 1986).

Plaintiffs contend that Laurens owed them a contractual duty; however, they have been unable to produce a single document wherein Laurens directly promised to ensure that Dr. Brown would have medical malpractice insurance coverage. Rather, Plaintiffs are seeking to read into a contract terms and conditions that simply are not there.

1) The Conditions of Admission form did not create a duty

The document that Plaintiffs contend forms the basis of their breach of contract claim is the Conditions of Admission form which they executed prior to each of their surgeries (hereinafter "the Contract"). Specifically, Plaintiffs point to the first sentence of the paragraph titled "Financial Agreement", which states,

> *"The undersigned agrees he signs as agent or as patient that in consideration of the* ***services to be rendered*** *to that patient, he hereby individually obligates himself to pay the account of the hospital, in accordance with the regular rates and terms of the hospital."* (emphasis added)

Plaintiffs contend this sentence, and specifically the highlighted language, is ambiguous because it does not define what services are to be rendered. They thus argue it should be read to create a duty on the part of Laurens to ensure that Dr. Brown had medical malpractice insurance coverage for their claims against him; however, such an interpretation is completely unreasonable.

As an initial matter, the mere fact that "services to be rendered" is not specifically defined does not render the contract ambiguous. See Stribling v. Stribling, 369 S.C. 400, 404, 632 S.E.2d 291, 293 (Ct. App. 2006)(lack of clarity on casual reading is not enough to render a contract ambiguous). Regardless, taking the terms in their plain, ordinary and popular sense, the purpose of

the sentence is unambiguous. It obligates patients to pay the bills they receive for the services rendered to them by the Hospital. "Services to be rendered," in the context of that paragraph, simply refers to those services that the Hospital actually provides and bills for, such as room charges, medications, and meals. The Hospital has never billed a patient for ensuring that an independent physician had medical malpractice insurance coverage, and it did not bill Plaintiffs for any such "service" in this case; therefore, that could not reasonably be considered a "service to be rendered."

Plaintiffs contend that "services to be rendered" should be interpreted to include an obligation on the part of Laurens to ensure privileged physician comply with the Medical Staff Bylaws and any contracts those physicians may have with the Hospital, as well as any laws and regulations. However, those things are not actually "services" rendered. At most, they go toward the standard of care for how services should be rendered at the Hospital. In essence, Plaintiffs seem to be contending that the Contract implies that services will be rendered in a certain manner; however, South Carolina does not recognize a cause of action for breach of an implied contract in the context of medical treatment. Banks v. Medical Univ., 314 S.C. 376, 444 S.E.2d 519 (1994).

Second, Plaintiffs' interpretation is unreasonable, because it requires one to ignore the plain and unambiguous language contained in other parts of the Contract. See McGill v. Moore, 381 S.C. 179, 188, 672 S.E.2d 571, 576 (2009) (When considering whether or not a contract is ambiguous, the contract is "read as a whole document so that one may not create an ambiguity by pointing out a single sentence or clause."); see also Ecclesiastes Prod. Ministries v. Outparcel Associates, LLC, 374 S.C. 483, 649 S.E.2d 494 (Ct. App. 2007) ("The parties' intention must be gathered from the contents of the entire agreement and not from any particular clause thereof."). The paragraph entitled "Medical and Surgical Consent" states,

"The patient's care is under the direction of the attending physicians and the

hospital is not responsible for any act or omission of the physicians.... The undersigned recognizes that most medical staff members furnishing services to the patient, including the radiologists, pathologist, anesthesiologists, and the like (are) independent contractors and not employees of the hospital."

While Plaintiffs apparently want to ignore it, this paragraph should have made it very clear to them that the Hospital was not responsible for any acts or omissions of Dr. Brown. To the extent that Dr. Brown's failure to purchase tail or prior bad acts coverage could be construed as a violation of the Bylaws, it would be his violation of the Bylaws, not Laurens's. Plaintiffs cannot reasonably argue that Laurens promised to ensure that Dr. Brown maintained medical malpractice insurance when Laurens clearly stated that it was not responsible for anything Dr. Brown did or failed to do.

2) Plaintiffs' subjective interpretation of the Contract is irrelevant

Regardless of whether a contract is unambiguous or ambiguous, the court's role in either instance is to interpret the contract based on the parties' intent at the time they entered into the agreement. Klutts Resort Realty , Inc. v, Down'Round Development Corp., 268 S.C. 80, 89, 232 S.E.2d 20, (1977); Mattox v. Cassady, 289 SC 57, 60-61, 344 SE2d 620, 622 (1986). Even assuming the Conditions of Admission form could be considered ambiguous, which it is not, summary judgment was nevertheless appropriate because there is no admissible evidence in the record that, at the time the parties entered into the contract, there was any agreement concerning or even a discussion of Dr. Brown's malpractice insurance.

In their brief, Plaintiffs contend that the circuit court erred in failing to consider their intent when they entered into the Contract with the Hospital. Plaintiffs contend "that their intent is based upon a recognition of the operational environment of a hospital." (Appellants' Brief, p. 12.) They contend that Mrs. McCord testified that it was her intent and understanding that part of "services to be rendered" included compliance by the Hospital with legal requirements which directly or

indirectly affected her medical care and legal rights.[4] (Id., p. 13.) They claim that it was Mrs. Sherfield's intent that the Hospital would comply with state and federal laws, as well as the Hospital rules and regulations and any contracts the physicians may have with the Hospital. They claim that Mrs. Sherfield knew at the time she executed the Contract that the Hospital required any doctor privileged there to have professional liability insurance. (Id. 13-14.) These claims by Plaintiffs are not supported by the facts in the record.

Plaintiffs' current subjective interpretation of the unambiguous language of the Conditions of Admission form is irrelevant. The law in South Carolina is well settled that one party's subjective interpretation of a contract is irrelevant when a court is constructing the contract's terms. M & M Group, Inc. v. Holmes, 379 S.C. 468, 476-77, 666 S.E.2d 262, 266 (Ct. App. 2008) (stating "[p]arties are governed by their outward expressions and the court is not free to consider their secret intentions"); Silver v. Abstract Pools & Spas, Inc., 376 S.C. 585, 593, 658 S.E.2d 539, 543 (Ct. App. 2008) (party to contract "is not permitted to reinterpret written contract terms midstream because he is unhappy with the contract he executed"); Ecclesiastes Prod. Ministries v. Outparcel Assocs., 374 S.C. 483, 498, 649 S.E.2d 494, 501 (Ct. App. 2007) ("Parties [to a contract] are governed by their outward expressions and the court is not at liberty to consider their secret intentions."); Bannon v. Knauss, 282 S.C. 589, 593, 320 S.E.2d 470, 472 (Ct. App. 1984) ("Interpretation of the contract is governed by the objective manifestation of the parties' assent at the time the contract was made. It does not depend on the subjective, after the fact meaning one party assigns to it.") (internal citations omitted).

4 In support of their arguments, Plaintiffs cite to their deposition testimony; however, their deposition transcripts were not part of the record prior to summary judgment being granted. Rather, Plaintiffs submitted the transcripts for the first time in support of their Motion to Alter or Amend Judgment. It is well established that a party cannot use a motion to reconsider, alter or amend a judgment to present evidence that could have been raised prior to the judgment but was not. Gartside v. Gartside, 383 S.C. 35, 43, 677 S.E.2d 621, 625 (Ct. App. 2009).

Plaintiffs have put forth no objective admissible evidence that either party outwardly expressed an intention at the time the Contracts were executed that "services to be rendered" would include Laurens ensuring that Dr. Brown would have medical malpractice insurance coverage for any claims Plaintiffs made against him. See North Am. Rescue Prods., Inc. v. Richardson, 411 S.C. 371, 379, 769 S.E.2d 237, 241 (2015) (Intent is determined by looking at the "objective manifestation of the parties' assent at the time the contract was made, rather than the subjective, after-the-fact meaning one party assigns to it."). While it is highly doubtful that either Mrs. McCord or Mrs. Sherfield gave any thought as to what "services to be rendered" meant prior to the filing of the instant action, it is undisputed that neither one of them discussed the language with anyone at the Hospital prior to their surgeries. (McCord Dep. p. 107:12-15, Sherfield Dep. p. 47:14-20.) Further, neither discussed whether Dr. Brown had medical malpractice insurance with anyone at the Hospital. (Pls.' Resps. to Defs.' Req. for Admis., ¶ 9.) Neither one of them had ever seen the Medical Staff Bylaws or had any knowledge of what the Bylaws required. (Id., ¶¶ 6-7.) Neither one of them knew about the Subsidy Contract between Dr. Brown and Laurens prior to the filing of the instant lawsuit. (Id., ¶ 8.)

In their brief, Plaintiffs contend that Mrs. Sherfield knew at the time she executed the Conditions of Admission form that Laurens required doctors privileged there to have insurance. (App. Brief p. 14.) That is a mischaracterization of Mrs. Sherfield's actual testimony. While she initially stated that she knew about the insurance requirement, Mrs. Sherfield later confirmed that her belief was not based on any knowledge she had of the hospital Bylaws or the Subsidy Contract, but rather her erroneous belief, based upon what her aunt had told her, that there was a law in South Carolina which required physicians to maintain medical malpractice insurance. (Sherfield dep. pp. 71:10 – 72:13.) Mrs. Sherfield's erroneous belief based upon her aunt's statement is insufficient to

create a genuine issue of material fact. See Yarborough and Co. v. Schoolfield Furniture Industries, Inc., 275 S.C. 151, 268 S.E.2d 42 (1980) (excluding affidavits based almost entirely on hearsay); James F. Flanagan, South Carolina Civil Procedure (second edition), at p. 450 ("dispute of fact must be established by evidence that would be admissible at trial"). Regardless, it would still only be evidence of her subjective intent, which, as previously noted, is irrelevant.

Again, there is simply no objective, admissible evidence that, at the time Plaintiffs executed the Conditions of Admission forms, either party outwardly expressed an intention that "services to be rendered" would include anything regarding Dr. Brown's medical malpractice insurance. To the contrary, as previously noted, Plaintiffs admitted under oath that the issue of Dr. Brown's insurance was never discussed. The only objective evidence is the express language in the Contract that Laurens was not responsible for any acts or omissions of Dr. Brown, which would include his failure to maintain insurance coverage for Plaintiffs' claims against him. Richardson, 411 S.C at 377-78, 769 S.E.2d at 240 (the "primary concern" of a court interpreting a contract is to look at the intent of the parties, and the best evidence of the parties' intent is the contract's plain language).

3) Neither Bylaws nor Subsidy Contract Created a Duty Owed to Plaintiffs

Plaintiffs argue that "services to be rendered" included ensuring that Dr. Brown complied with the insurance requirements in the Bylaws and Subsidy Contract. As an initial matter, there is no evidence that Dr. Brown failed to comply with the requirements of the Bylaws and/or the Subsidy Contract. It is undisputed that, at the time of the surgeries on Plaintiffs, Dr. Brown had the required insurance. Plaintiffs contend that he fell out of compliance when he switched policies in July of 2009 and failed to purchase tail coverage or prior bad acts coverage; however, there is nothing in the Bylaws or the Subsidy Contract that specifically required Dr. Brown to purchase tail coverage or prior bad acts coverage, nor is there any evidence in the record that Laurens considered Dr. Brown to

be in violation of the Bylaws or in breach of the Subsidy Contract by his failure to purchase tail or prior bad acts coverage.

Nevertheless, even if the Bylaws and/or the Subsidy Contract could somehow be interpreted to have put a requirement on Dr. Brown to purchase tail or prior bad acts coverage, it is unclear why Plaintiffs believe that somehow created a duty owed to them by Laurens. Since Defendants first moved for summary judgment, Plaintiffs have continually argued that they are not attempting to make a third-party beneficiary claim. (*see i.e.* App. Brief pp. 14-15.) However, Plaintiffs appear to be talking out of both sides of their mouths. Plaintiffs point to their Second Amended Complaint and say the never alleged a third-party action, but rather alleged "breach of the contract in seven separate particular failures..." (App. Brief p. 15.) [5] However, those first two particulars are allegations that Laurens failed to require Dr. Brown to comply with requirements of the Bylaws and the Subsidy Contract. (Sec. Am. Compl. ¶ 73(a) and (b).) If Plaintiffs are not claiming to be third-party beneficiaries, then they have no basis for claiming those documents created a duty owed to them.

While Plaintiffs say they are not making a third-party beneficiary claim, they specifically argue the insurance requirements in the Bylaws and Subsidy Contract exist for their benefit. (see i.e. App. Brief p. 9.) However, there is no evidence that Laurens intended the insurance requirement to inure to the benefit of patients. Plus, Plaintiffs' contention is inconsistent with South Carolina law. See Trancik v. USAA Ins. Co., 354 S.C. 549, 581 S.E.2d 858 (Ct. App. 2003) ("Third-party-liability-insurance contracts are generally indemnity contracts whereby the insurer, or the first party, agrees to pay the insured, or the second party, the amount of any damages the insured may become legally

5 Statements in a party's pleadings are generally binding on the party. See Johnson v. Alexander, 413 S.C. 196, 202, 775 S.E.2d 697, 700 (2015)(citing Elrod v. All, 243 S.C. 425, 436, 134 S.E.2d 410, 416 (1964))

liable to pay a third party; thus, the third party, or the incidental beneficiary, does not have a contractual relationship with the insurer and cannot maintain an action against the insurer for breach of the insurance contract.") At best, Plaintiffs would be incidental beneficiaries of the Medical Staff Bylaws and Subsidy Contract, but that would not give them the right to sue to enforce those documents. Id.

Regardless, even if Plaintiffs could be considered intended beneficiaries, such status would only give them standing to sue Dr. Brown as the promisor, not Laurens as the promisee. Under the terms of both the Bylaws and the Subsidy Contract, the obligation to maintain insurance belonged to Dr. Brown. To the extent his failure to purchase tail coverage meant he had not fulfilled his obligations, Plaintiffs would, at best, have been able to sue Dr. Brown for breach of the Bylaws and Subsidy Contract, but that would not give them the right to sue Laurens. See Sullivan v. U.S., 625 F.3d 1378 (Fed. Cir. 2010) (holding plaintiffs could not maintain a breach of contract action against Postal Service for failing to enforce a contract with a transportation company, and noting that the contract provision requiring the contractor to purchase liability insurance for its vehicles was intended to protect the Postal Service from potential risk and plaintiffs were at best incidental beneficiaries); Hesse v. Long and Foster Real Estate, Inc., No. 1:11cv506, 2012 WL 1427793 (E.D.Va.2012) (noting that no jurisdiction recognizes a theory of liability whereby a third party to a contract can sue the non-breaching party for failure to enforce the contract).

And to the extent that Plaintiffs may be contending as much (see App. Brief p. 25), the Bylaws and/or the Subsidy Contract did not create a duty owed to Plaintiffs as the result of a voluntary undertaking on the part of Laurens. First, a voluntary undertaking exists when one undertakes to render services to another which he should recognize as necessary for the protection of someone else. See *Restatement (Second) of Torts* § 323(a) (1965). In regards to the Bylaws and/or

the Subsidy Contract, Laurens did not undertake to render any services. Again, pursuant to both those documents, it was Dr. Brown who undertook to render OB/GYN services and agreed to maintain medical malpractice insurance while rendering those services. Nowhere in either of those documents does Laurens state that it will ensure that Dr. Brown will maintain insurance.

But regardless, even if Laurens had undertaken the responsibility to ensure that Dr. Brown maintained insurance, it would not have created a duty owed to Plaintiffs, because the undertaking did not make Plaintiffs situation worse, nor did Plaintiffs rely on the undertaking to their detriment. See Staples v. Duell, 329 S.C. 503, 494 S.E.2d 639 (Ct. App. 1997) (holding defendant's failure to follow an internal policy which voluntarily undertook to conduct inspections of rural property was not actionable). It is admitted that Plaintiffs had never seen or read the Medical Staff Bylaws or the Subsidy Contract prior to their surgeries, and they had no knowledge of the terms and conditions of those documents. (See Plaintiffs' Responses to Defendants' Requests for Admissions, ¶¶ 6-8.) They did not discuss those documents or the requirement that Dr. Brown have medical malpractice insurance with anyone at the Hospital prior to their surgeries. (Id.) They simply knew nothing about the medical malpractice insurance requirement, and thus could not have relied on that requirement to their detriment.

B. A "Special Relationship" Did Not Create a Duty in Tort

Plaintiffs also contend the "special relationship" between the parties created a duty aside and apart from any duty that may have been created by the Contract; however, it is unclear what separate duty Plaintiffs are referring to. They appear to be arguing that the special relationship created the same duty they also argued was a contractual duty – a duty on the part of Laurens to comply with all laws and regulations and to ensure that Dr. Brown complied with insurance requirements in the Bylaws and the Subsidy Contract. The law does not allow Plaintiffs to argue a breach of the same

duty under both a contract and tort theory. See Tommy L. Griffin Plumbing & Heating Co. v. Jordan, Jones, & Goulding, Inc., 320 S.C. 49, 54-55, 463 S.E.2d 85, 88 (1995).

Regardless, the "special relationship," to the extent there even was one, did not create a duty on the part of Laurens to ensure that Dr. Brown had medical malpractice insurance coverage for Plaintiffs' claims. Plaintiffs continually argue that Laurens had an obligation to comply with all state and federal laws and regulations, but Plaintiffs have been unable to point to a single law or regulation which required Laurens to ensure that Dr Brown maintained medical malpractice insurance. In fact, under South Carolina law, doctors are free to forego medical malpractice insurance coverage if they so choose. And, as fully argued above, the insurance requirements in the Bylaws and Subsidy Contract did not create a duty owed to Plaintiffs. Again, Plaintiffs were at most incidental beneficiaries of those requirements, which would not give them standing to sue to enforce those requirements, and would certainly not give them grounds to sue Laurens.

In addition, Plaintiffs rely on several cases in support of their "special relationship" argument that are distinguishable from the instant case. In South Carolina State Ports Authority v. Booz-Allen & Hamilton, Inc., 289 S.C. 373, 346 S.E.2d 324 (1986), the Court held that a duty of care ran from a consultant to the commercial competitor the consultant was hired to critique when the consultant undertook to objectively analyze and compare the attributes of the commercial competitors for the purpose of giving one a market advantage over the other. 289 S.C. at 376-77. In Tommy L. Griffin Plumbing & Heating Co., the Court held the economic loss rule and lack of privity did not prevent a contractor from maintaining a tort action against a design engineer. 320 S.C. 49. In both cases, the Court held the defendants owed a duty to the plaintiffs to perform their contractual duties owed to a third party with due care. That is not what Plaintiffs are arguing should be done in this case. Rather, Plaintiffs are seeking to have Defendants held liable for Dr. Brown's failure to exercise due care in

performing his contractual duty to maintain insurance.

Finally, it would be contrary to public policy and the intentions of the Legislature in South Carolina to hold that Laurens owes a duty to its patients to ensure that independent physicians maintain medical malpractice insurance. As previously mentioned, there is no law in South Carolina that requires doctors to maintain medical malpractice insurance. In addition, Laurens and GHS are both governmental entities subject to the South Carolina Tort Claims Act, S.C. Code Ann. § 15-78-10, et seq. (1976, as amended), and it and its agents and employees are, therefore, entitled to all rights, privileges, defenses, limitations, and immunities afforded by the Act and afforded by the doctrine of sovereign immunity, as is retained by the Act. See Murphy v. Richland Mem. Hosp., 317 S.C. 560, 455 S.E.2d 688 (1995) (citing Benton v Roger C Peace, 313 S.C. 520, 443 S.E.2d 537 (1994)). Pursuant to the Act, a governmental entity cannot be held liable for the acts or omissions of an independent contractor. S.C. Code § 15-78-60(20); see also Smith v. Reg'l Med. Ctr., 394 S.C. 110, 713 S.E.2d 656 (Ct. App. 2011) (holding governmental hospital could not be held liable for the negligent acts of an independent contractor physician). Therefore, it is the public policy of this State and the intent of the Legislature that Laurens cannot be held liable for Dr. Brown's failure to have insurance coverage for Plaintiffs' claims. Further, the Act retains immunity for governmental entities for failing to enforce written policies, S.C. Code § 15-78-60(4); therefore, even if it could be said that Laurens failed to enforce its Bylaws, it would have immunity for failing to do so.

Plaintiffs were allegedly injured both physically and financially by Dr. Brown's acts and omissions. To the extent they seek to recover for those injuries, they must look to Dr. Brown, and Dr. Brown alone, for recovery.

III. Additional Sustaining Grounds for Summary Judgment

While granting summary judgment on the basis that Defendants did not owe a duty to

Plaintiffs to ensure Dr. Brown had medical malpractice coverage for their claims, the circuit court chose not to address Defendants' proximate cause and statute of limitations arguments in favor of summary judgment. (Order, p. 10.) However, those arguments do set forth additional grounds for why the circuit court's order granting summary judgment should be sustained.

A. Plaintiffs' Injuries Were Not Proximately Caused by Defendants' Acts or Omissions

Plaintiffs' inability to collect their judgments has not been the result of any act or omission on the part of Laurens. Their current predicament can be blamed on several things, but none of those things are Laurens's fault. First, had Plaintiffs put Dr. Brown on notice of their claims at the time they first became aware of the injuries he allegedly caused them, there would have been coverage through Dr. Brown's JUA policy. It was not Laurens's fault that they each decided to wait so long to tell anyone that they felt they had been injured by Dr. Brown's negligence. Second, it was not Laurens's fault that Dr. Brown switched insurance carriers and failed to purchase tail coverage. And finally, it was not Laurens's fault that Dr. Brown decided to move out of the country.

In their Second Amended Complaint, Plaintiffs appear to argue that Laurens should have informed them that Dr. Brown had a claims-made policy in sufficient time for them to make a claim (Sec. Am. Compl. ¶¶ 66-68); however, their own "hospital expert" refuted that contention and stated that, in his opinion, Laurens had no duty to do anything until it found out that Dr. Brown had switched policies and failed to purchase tail coverage or prior bad acts coverage. (See Charles Hyde, II, Ph.D. Dep., April 8, 2016, p. 123:18-23.) But at that point, the damage had been done and there was nothing anyone - besides Dr. Brown - could do to rectify the situation.

Plaintiffs contend that Laurens should have done something to force Dr. Brown to purchase tail coverage, but Laurens could not force Dr. Brown to do anything. Dr. Brown was not an

employee of Laurens. Laurens had no direct control over him. The most Laurens could have done was terminate his privileges and require him to repay the amounts forwarded under the Subsidy Contract, but there is no evidence that doing either of those things would have prompted Dr. Brown to purchase tail coverage. In fact, Laurens ultimately did both of those things, and it did not have any impact on Dr. Brown's decision to not purchase tail coverage.

Plaintiffs' "hospital expert" conceded that Laurens could not have forced Dr. Brown to purchase tail coverage, but argued that Laurens had a duty to purchase tail coverage on Dr. Brown's behalf since he refused. However, Plaintiffs' insurance expert conceded that in order for a company to be able to purchase liability insurance coverage for a person, it must have an insurable interest in that person. (See James M. Carson, Ph.D. Dep., July 7, 2016, pp. 35:17 – 36:8.) Therefore, for Laurens to have had an insurable interest in Dr. Brown, there had to be a possibility that Laurens could be held vicariously liable for Dr. Brown's actions, but as noted above, that was not a possibility under the Tort Claims Act. See Smith, supra. Accordingly, under the law, Laurens could not have purchased tail coverage on Dr. Brown's behalf even if it wanted to.

The fact is that once Dr. Brown made the decision to switch carriers and declined to purchase tail coverage or prior bad acts coverage, there was nothing anyone, other than Dr. Brown, could do to ensure that Plaintiffs would be compensated for the injuries he allegedly caused them. It was solely Dr. Brown's fault that Plaintiffs were injured and it was Dr. Brown's fault (not withstanding Plaintiffs' failure to timely file their claims) that Plaintiffs have been unable to collect any money for their alleged injuries.

B. Plaintiffs' Claims are Barred by the Statute of Limitations

Under the Tort Claims Act, the applicable statute of limitations is two years. S.C. Code Ann. § 15-78-110. South Carolina applies the discovery rule to claims for negligence. Republic Contr.

Corp. v. South Carolina Dep't of Highways & Pub. Transp., 332 S.C. 197, 503 S.E.2d 761 (Ct. App. 1998). Under the discovery rule, the statutory period begins to run when a person knew or by the exercise of reasonable diligence should have known that he had a cause of action. S.C. Code Ann. § 15-3-535 (2008); Smith v. Smith, 291 S.C 420, 426, 354 S.E.2d 36, 40 (1987). The test is objective and is based upon when a person could or should have known that a cause of action might exist in his or her favor, rather than when a person obtains actual knowledge of either the potential claim or of the facts giving rise thereto. Burgess v. American Cancer Soc., South Carolina Div., Inc., 300 S.C. 182, 386 S.E.2d 798 (Ct. App. 1989).; see also Austin v. Conway Hosp., Inc., 292 S.C. 334, 339, 356 S.E.2d 153, 156 (Ct. App. 1987) (quoting Rogers v. Efird's Exterminating Co., Inc., 284 S.C. 377, 379, 325 S.E.2d 541, 542 (1985)). Further, the Supreme Court of South Carolina held in Wiggins v. Edwards, 314 S.C. 126, 128, 442 S.E.2d 169, 170 (1994):

> *"The focus is upon the date of discovery of the injury, not the date of discovery of the wrongdoer: The important date under the discovery rule is the date that a plaintiff discovers the injury, not the date of the discovery of the identity of another alleged wrongdoer. If, on the date of injury, a plaintiff knows or should know that she had some claim against someone else, the statute of limitations begins to run for all claims based on that injury." (emphasis added).*

Applying the law to the facts of this case, it is clear that Plaintiff's claims are barred as matter of law. Plaintiffs are trying to recover damages sustained when they were allegedly injured by Dr. Brown; therefore, the statute of limitations for all claims based on those injuries began to run when those injuries occurred. Mrs. McCord felt she had been injured by Dr. Brown following her second surgery on February 19, 2009; therefore, all of her claims began to accrue on February 19, 2009. Mrs. Sherfield was told immediately following her surgery on May 29, 2009 that there had been complications; therefore, all of her claims began to accrue on May 29, 2009. Plaintiffs did not file this action until March of 2014, nearly three years beyond the statute of limitations.

Plaintiffs have argued that their claims against the hospital did not begin to accrue until they

discovered that Dr. Brown did not have medical malpractice insurance coverage for their claims against him (see Pl. Mem. in Opp. to Sum. J., pp. 23-24), but that position is inconsistent with the damages Plaintiffs are seeking to recover. Plaintiffs have alleged that they are entitled to recover the full amount of the judgments they received against Dr. Brown.[6] (See Sec. Am. Compl. ¶¶ 83-85.) Those judgments were compensation for the injuries allegedly caused by Dr. Brown during the aforementioned surgeries. Therefore, in this case, Plaintiffs are again seeking to be compensated for the injuries they sustained during those surgeries, and, as previously stated, all claims to recover for those injuries began to accrue at the time of the injuries in 2009. Wiggins, supra.

Nevertheless, even assuming that Plaintiffs claims did not accrue until they knew about the problem with Dr. Brown's insurance, their claims against Defendants would still be barred by the applicable statute of limitations. It is admitted that as of December 1, 2011 Plaintiffs, through their attorney, were aware of the possibility that Dr. Brown did not have medical malpractice insurance coverage for their claims against him. (See Plaintiffs' Response to Defendants' Requests for Admission, ¶ 5.) Therefore, even assuming the lack of insurance caused a distinct and separate injury, which again would be inconsistent with Plaintiffs' claimed damages in this case, Plaintiffs were aware of that injury as of December 1, 2011, which means they were still several months beyond the applicable statute of limitations when they filed this action on March 26, 2014.

In an attempt to get around the statute of limitations, Plaintiffs have argued they did not suffer a loss until judgments were rendered against Dr. Brown, which they argue would have been

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6 Plaintiffs have been inconsistent in how much they claim they are entitled to recover in this case. In their Second Amended Complaint they alleged they were entitled to recover the full amounts of the default judgments that they received in the actions against Dr. Brown (¶¶ 83-85). They have repeated that claim in their Initial Brief (p. 3); however, in their Memorandum in Support of their Rule 59(e) Motion, Plaintiffs acknowledged for the first and only time that the most they could recover would be the amount of insurance coverage that possibly would have been available to them had Dr. Brown purchased tail coverage or prior bad acts coverage. It is clear from Dr. Brown's policy that would have been at most $1,000,000 per claim. (See JUA Policy pp. 7 and 12.)

covered by insurance but for Laurens's failure to ensure Dr. Brown had insurance. (see Pl. Mem. in Opp. to Sum. J., pp. 24-25.) Again, that argument contradicts their damages claims, since they are claiming the full amount of the damages they received in the default judgments, as opposed to the amounts that would have been covered by insurance. This argument by Plaintiffs highlights many of the fallacies of this case. First, it proves that Plaintiffs are essentially contending that Laurens should indemnify Dr. Brown when there is no evidence that Laurens ever agreed to do so. Second, it emphasizes how speculative their claims are. Despite what Plaintiffs contend, even if Dr. Brown had purchased tail coverage or prior bad acts coverage, they would not have recovered the entirety of their judgments. Dr. Brown had a $1M/$3M policy, so Plaintiffs would have received at most $1M each. And it is certainly a possibility that, given the fact that several other claims were made against Dr. Brown in 2009 (see App. Initial Brief, p. 5, fn 1), he may have already exceeded his $3M annual aggregate, which would have precluded Plaintiffs from receiving any insurance proceeds. In addition, the testimony from Plaintiffs' insurance expert confirmed that Dr. Brown's move out of the country and subsequent refusal to participate in the defense of the case could have provided grounds for his carrier to deny coverage for the claims altogether. (see Dep. Of James M. Carson, Ph.D., July 7, 2016, pp. 18-19). Finally, if Plaintiffs' claims are truly dependent upon their inability to collect the judgments, then their claims still have not ripened, as they have at least five more years in which they could enforce the judgments against Dr. Brown. See S.C. Code § 15-35-810.

C. While Plaintiffs may be in an Unfortunate Situation, Their Grievances are Misdirected to the Courts

Much of Plaintiffs' Brief is dedicated to putting forward "facts" and policy arguments as to why physicians and/or hospitals should be required to carry medical malpractice insurance. (see e.g., Appellants' Brief at 8-10.) However, under our State Constitution and the case law, these policy

considerations are for the Legislature, not this Court. The question of whether a physician should be required to purchase malpractice insurance and, more particularly, whether a hospital has any duty to ensure that a physician with privileges at the hospital has purchased such insurance, should be left to the Legislature, which is empowered by our State Constitution to make all of the policy decisions surrounding this issue and is best positioned to create and fund a regulatory scheme on this question going forward.

A fundamental underpinning of our system of government, found in both the United States and the South Carolina Constitutions, is the basic, core concept that there are three distinct branches of government, each with separate and distinct functions and roles in the operation of government. One branch does not and cannot perform any function of the other two branches of government. See S.C. Const. Art. I, § 8; Hampton v. Haley, 403 S.C. 395, 743 S.E.2d 258 (2013); Condon v. Hodges, 349 S.C. 232, 244, 562 S.E.2d 623, 630 (2002); McLeod v. McInnis, 278 S.C. 307, 312, 295 S.E.2d 633, 636 (1982).

It is fundamental to the separation of powers mandate that "legislative and judicial powers are entirely separate." State v. Bates, 198 S.C. 430, 436, 18 S.E.2d 346, 348 (1941). The courts in South Carolina "[have] no legislative powers; it is [the court's] province to construe laws, not make them." Santee Cooper Resort, Inc. v. South Carolina Pub. Svc. Comm'n, 298 S.C. 179, 184, 379 S.E.2d 119, 122 (1989); see also Am. Petroleum Inst. v. South Carolina Dep't of Revenue, 382 S.C. 572, 579, 677 S.E.2d 16, 20 (2009). The judicial branch shall not act in a way that infringes either directly or indirectly on any legislative function. See Brown v. State, 198 S.C. 430, 436, 18 S.E.2d 346, 348-49 (1941); see also Smith v. Wallace, 295 S.C. 448, 452, 369 S.E.2d 657, 659 (Ct. App. 1988) (stating "[t]his Court has no legislative powers").

Article III, § 1 of the South Carolina Constitution confers all legislative powers and functions

solely on the South Carolina General Assembly. See Hampton, 403 S.C. at 403, 743 S.E.2d at 262; Calhoun Life Ins. Co. v. Gambrell, 245 S.C. 406, 411, 140 S.E.2d 774, 776 (1965). As stated in Hampton, "[i]ncluded in the legislative power is the sole prerogative to make policy decisions; to exercise discretion as to what the law will be." 403 S.C. at 403, 743 S.E.2d at 262 (internal citation omitted). According to our Supreme Court, "while non-legislative bodies may make policy determinations when properly delegated such power by the Legislature, absent such delegation, policy making is an intrusion upon the legislative power." Id. at 404, 743 S.E.2d at 262. Similarly, in Amisub of S.C., Inc. v. S.C. Dept. of Health and Envtl. Control, 407 S.C. 583, 596, 757 S.E.2d 408, 415 (2014), our Supreme Court stated that "we agree with the Supreme Judicial Court of Massachusetts that a 'principle of great importance in our triparte form of government is "that it is for the Legislature . . . to determine finally which social objectives or programs are worthy of pursuit." ' " (internal citations omitted).

Beyond policymaking, the legislative powers conferred to the General Assembly also include "the police power" of the State, which is the power to make laws for the general benefit of the public or for the benefit of a specific group. Sammons v. City of Beaufort, 225 S.C. 490, 499, 83 S.E.2d 153, 157 (1954); Gasque, Inc. v. Nates, 191 S.C. 271, 277-78, 2 S.E.2d 36, 39 (1939). The appellate courts of this State have routinely held that the regulation of hospitals and medical care providers is a legislative function. E.g., Dantzler v. Callison, 230 S.C. 75, 92, 94 S.E.2d 177, 186 (1956) (requirements for who is to diagnose and find out what is the cause and treatment of an illness is a legislative one; "it is not a judicial question"); Law v. City of Spartanburg, 148 S.C. 229, 238, 146 S.E. 12, 15 (1928) (holding the General Assembly has the constitutional power to create and regulate hospitals in South Carolina); State v. Barnes, 119 S.C. 213, 217-18, 112 S.E. 62, 63-64 (1922) (determining licensing requirements for chiropractors is a legislative function, not a judicial one);

Myrtle Beach Hosp. v. City of Myrtle Beach, 333 S.C. 590, 595, 510 S.E.2d 439, 441 (Ct. App. 1998), *aff'd as modified by* 341 S.C. 1, 532 S.E.2d 868 (2000) (holding whether city should be required to pay for the hospital services rendered to pre-trial detainees was "for the legislature to decide and not the court system").

The South Carolina Legislature has enacted legislation making insurance mandatory in certain circumstances. See, *e.g.*, S.C. Code § 56-9-10, *et seq.* ("Motor Vehicle Financial and Responsibility Act"); S.C. Code § 42-5-20 (requiring insurance or proof of financial ability to pay under the South Carolina Workers' Compensation Law). Over the years, the South Carolina Legislature has passed various laws regulating medical malpractice claims,[7] but it has never required that a physician or medical care provider have medical malpractice insurance, let alone imposed a requirement on a third party, such as a hospital, to ensure that physicians have medical malpractice coverage. This policy choice must be honored by this Court. Smith v. Tiffany, 419 S.C. 548, 799 S.E.2d 479, 485 (2017) ("in honoring separation of powers, we adhere to the principle that a court must not reject the legislature's policy determinations merely because the court may prefer what it believes is a more equitable result"); Scholtec v. Estate of Reeves, 327 S.C. 551, 559, 490 S.E.2d 603, 607 (Ct. App. 1997) (holding that, if the legislature intended a certain result, "we believe that it would have expressly stated so . . .").

To that end, no appellate court in this State has ever held that a physician has a duty to purchase medical malpractice insurance to provide benefits to a patient in the event the patient is injured by the alleged negligence of the physician. And certainly, no court in this State has imposed a requirement that a hospital ensure that physicians with privileges at the hospital have medical malpractice coverage in place. "In the exercise of proper judicial self-restraint, the courts should

7 See e.g. The Medical Malpractice Reform Act of 2005, S.C. Code § 15-79-110, et. seq.

leave it to the people, through their elected representatives in the General Assembly, to say whether or not [a longstanding common law principle] should be revised or discarded." Page v. Winter, 240 S.C. 516, 519, 126 S.E.2d 570, 572 (1962); Rogers v. Florence Printing Co., 233 S.C. 567, 574, 106 S.E.2d 258, 261-62 (1958).

Even if the Court sympathizes with Plaintiffs' policy arguments, it would violate the separation of powers mandate in our State Constitution for this Court to turn that sympathy into the result requested by Plaintiffs. See Gallman v. Springs Mills, 201 S.C. 257, 260, 22 S.E.2d 715, 716 (1942) (noting that "it is not within [the court's] power to translate [the court's] sympathy and conviction into law. That is a strictly legislative function."). While Dr. Brown's failure to obtain tail or prior bad acts coverage may result in an unfortunate financial outcome for Plaintiffs here, their policy concerns should be addressed to their elected state representatives, not this Court. See Carnival Corp. v. Historic Ansonborough Neighborhood Ass'n, 407 S.C. 67, 81, 753, 846, 853 (2014). The Legislature is best positioned to make the policy decisions about whether medical malpractice insurance should be required, what type of insurance would be best, who, if anyone, should be required to ensure that the physician or medical care provider has such insurance, and to create and fund a regulatory scheme, through the appropriate agency, to regulate the terms and conditions of any such insurance coverage, including whether purchasing tail coverage for claims made policies should be required.

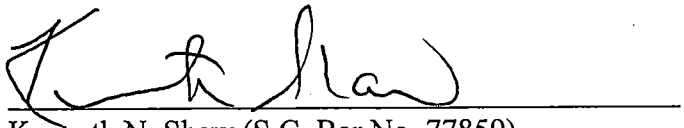
CONCLUSION

Plaintiffs have submitted "voluminous" amounts of information and set forth a litany of "facts" in an attempt to confuse the issue and create a question of fact, but this case is not nearly as complicated as Plaintiffs would have this Court believe. It is really quite simple. Plaintiffs were allegedly injured by Dr. Brown and they each brought medical malpractice claims against him. His

medical malpractice insurance carriers denied coverage for their claims. Dr. Brown moved out of the country while the claims were pending, which allowed Plaintiffs to obtain default judgments against him. They have been unable to collect those judgments. Plaintiffs correctly chose not to name Defendants in their actions against Dr. Brown, because they apparently recognized that Defendants could not be held vicariously liable for Dr. Brown's alleged medical malpractice, yet they now want Defendants to pay judgments rendered in actions Defendants were not parties to. It makes no sense that Defendants could somehow be vicariously liable for Dr. Brown's failure to pay the judgments rendered against him when everyone agrees they were not and could not have been vicariously liable for the underlying medical malpractice, yet that is what Plaintiffs are essentially arguing. While Plaintiffs are in a difficult position, they have known since they signed the Conditions of Admission forms that Defendants were not responsible for any acts or omissions of Dr. Brown, which would include his current failure to pay the judgments rendered against him.

Wherefore, for the reasons stated herein, Respondents Laurens County Health System and Greenville Health System respectfully request that this Court affirm the Order issued by Circuit Judge Eugene Griffith, Jr. granting summary judgment in favor of Respondents.

HAYNSWORTH SINKLER BOYD, P.A.



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July 24, 2017

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM LAURENS COUNTY
Court of Common Pleas

Eugene C. Griffith, Jr., Circuit Court Judge

Appellate Case No. 2017-001064

Chris Katina McCord, Christopher McCord, Janice Sherfield, and Jerry Sherfield,..... Appellants

v.

Laurens County Health Care System and Greenville Health System..... Respondents

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PROOF OF SERVICE

This is to certify that the foregoing INITIAL BRIEF OF RESPONDENTS AND DESIGNATION OF MATTER TO BE INCLUDED IN THE RECORD ON APPEAL were served in the above-referenced case by placing copies of said documents in the United States Mail on this the 24th day of July, 2017, addressed as follows:

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McGowan, Hood & Felder, LLC
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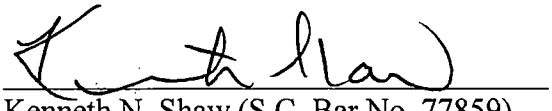
HAYNSWORTH SINKLER BOYD, P.A.



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July 24, 2017

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
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Re: Chris Katina McCord, et al. v. Laurens County Health Care System, et al.
Appellate Case No. 2017-001064

Dear Ms. Kitchings:

Please find enclosed for filing the original and one copy each of Initial Brief of Respondents and Designation of Matter to be Included in the Record on Appeal, together with our Certificate of Service of same. After filing, please return file-stamped copies to the undersigned in the self-addressed, postage paid envelope enclosed for your convenience.

By copy of this letter, I am serving a copy of same upon counsel for the Appellants, Joseph G. Wright, III, Esq.

Please feel free to contact me should you have any questions or concerns.

Sincerely yours,

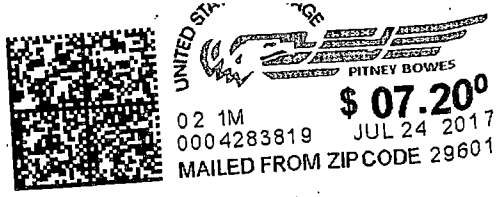
HAYNSWORTH SINKLER BOYD, P.A.

Kenneth N. Shaw

KNS:dlh

Enclosure

cc: Joseph G. Wright, III, Esq.



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